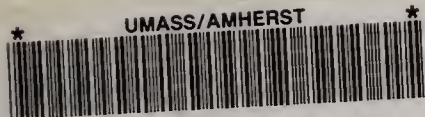


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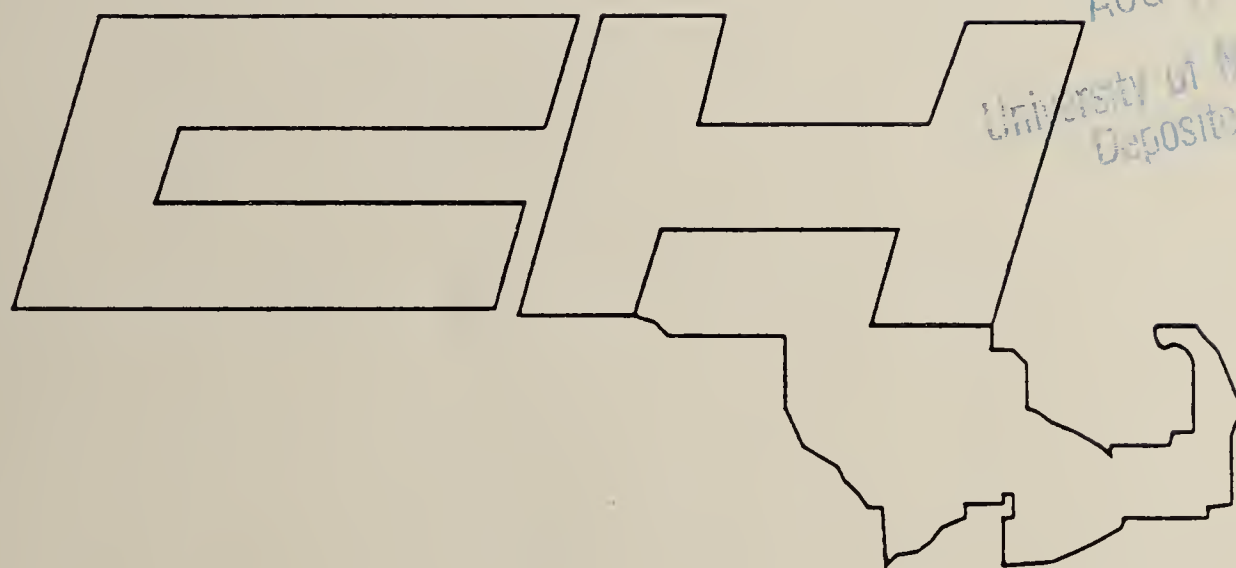
Common Health

Health Care For All

GOVERNMENT
COLLECTION

AUG 1993

University of Massachusetts
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A Reference Guide

July, 1988

Commonwealth of Massachusetts

931/74



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Introduction

CommonHealth

I- 1



On July 1, 1988, the Welfare Department's role in providing "Health Care for All" was expanded to include groups that were previously unable to receive health care coverage. A new program, called CommonHealth, was developed that extends health coverage to the following groups:

- children with disabilities;
- working adults with disabilities; and
- our clients who go to work and are no longer eligible for Medicaid.

Providing basic health care coverage to our clients who go to work or a contribution to the cost of their employer-sponsored health insurance is often the support that can help them remain independent. It can also provide them with an incentive to go to work if they know they will be covered, especially for the interim period before they are picked up by their employer's insurance.

CommonHealth allows our clients to have some choice in the health care coverage that is available to them. It also provides them with a sense of well-being knowing they and their families have access to health care. You, as their worker, are their prime information source and motivating agent. You can provide them with the information they need to make the best choice for themselves and their families.

**Worker
Responsibilities**



Confidence in knowing that our clients will have medical coverage for themselves and their families may just be the answer to those who fear that the loss of medical coverage outweighs their well-intended effort to work. **CommonHealth** provides a vital link in helping our clients make the transition from welfare to work.

You, as workers, should actively encourage and market HMO enrollment to your clients well before their cases close. Whenever clients come to the office or contact you for any reason, discuss with them the advantage of choosing a health benefit package that best suits their needs and that will be in place for them when they get a job and become self-sufficient.

Possible HMO enrollment incentives that you can discuss with potential enrollees include the following.

- Convenience of provided services
- Availability of a private physician, selected by the enrollee, to coordinate all of the enrollee's health care needs
- Convenience of having the entire family's medical records at a single location
- Simplified access to specialized medical providers
- High quality service
- An end to the search for medical providers willing to accept Medicaid payment
- Issuance of a membership card identical to all other HMO members
- Availability of pharmacy benefits

Since the availability of options can often be complex and confusing to clients, the opportunity for you to guide your client toward the most suitable coverage is very important. Helping your clients to receive the broadest and most complete coverage available can provide the assurance that health needs can and will be met while they are employed.

Overview



Often the realization that medical services may be lost results in the decision not to work. The security of knowing that health care is available through **CommonHealth** provides your clients with the incentive needed to go to work and removes one of the barriers that has prevented them from achieving independence.

CommonHealth provides this incentive in three ways by providing:

- "close-the-gap" coverage while your client awaits employer-provided health care benefits;
- suitable medical coverage to meet your client's major medical needs when no employee health insurance is offered; or
- a monthly contribution toward the cost of your client's employer-offered health insurance premium.

Under the Welfare to Work program, **CommonHealth** provides coverage for up to 24 months to former welfare recipients who have gone to work and whose income does not exceed 185% of the federal poverty level.

Three choices are available to CommonHealth participants:

- CommonHealth Plus offers comprehensive health insurance coverage through the HMO of your client's choice;
- CommonHealth Basic provides a limited range of medical services available from CommonHealth providers who have agreed to participate in the program; and
- CommonHealth Assist provides a monthly payment toward the cost of your client's employer-offered health insurance.

Information and a CommonHealth enrollment form are mailed to all individuals and families who lose their Medicaid because of increased earnings. Clients who have closed for other reasons, such as "at client's request", also receive the mailing since termination due to earnings is often hidden by another closing reason. By notifying the broad range of terminated cases, the likelihood of missing potential eligibles is minimized.

Remember:

- Stress the importance of early enrollment in **CommonHealth** since CommonHealth benefits are only available for up to 24 months after Medicaid closes.
- Failure to enroll either before Medicaid closes or immediately after Medicaid closes decreases the number of months CommonHealth coverage is available. Early enrollment also eliminates any gaps in coverage.

**Worker
Responsibilities**

Process CommonHealth Enrollment Form

- Complete SMARTS Transmittal Sheet for key entry into your application tracking system.
- Check Recipient Masterfile for current case status.
 - If case has reopened or has become eligible under another category of assistance, or if case is eligible for Medicaid, send CommonHealth denial letter.
- Review enrollment form and verification received.
 - Income and availability of employer insurance must be verified (see pages A-2 and A-3).
 - Contact client if verification of income and/or availability of employer insurance is needed.
- If employer insurance is available, but only after a waiting or probation period, contact client to determine when insurance will be available.

- If insurance is available through the employer, contact client if verification of the type of coverage and cost of the premium is needed.
- If employer insurance is not available, determine whether enrollee wants CommonHealth Basic or CommonHealth Plus (HMO).
 - Check MMIS TPL screen to determine applicant's (Health Choices) HMO enrollment status.

Client returns enrollment form indicating CommonHealth Basic or no choice.

- Contact client either by phone or mail to discuss benefit packages and the advantages of choosing CommonHealth Plus (HMO).
- If client chooses CommonHealth Basic, tell him or her to contact you if he or she wants to switch to CommonHealth Plus at anytime in the future.

Client chooses CommonHealth Plus or is already enrolled in HMO.

- If client is already enrolled in HMO, continue HMO membership.
- If he or she is not yet enrolled in an HMO:
 - Contact client to explain how benefit package differs from Medicaid and, if possible, to determine in which HMO the client is interested.
 - Discuss managed-care options with client.
 - Set up appointment for client with HMO representative.
 - Send referral form to HMO advising them to contact client.
 - Follow up with client within 30 days to determine whether he or she met with HMO representative.
 - If eligible, he or she will receive a MassHealth card for his or her use until enrolled in HMO.

Client returns enrollment form indicating that employer-offered insurance is available to the employee, but not available to cover the employee's spouse or children.

- Complete PACES Worksheet and TD to open CommonHealth Assist for employee only, no eligible dependents.
- Complete Paces Worksheet and TD to open CommonHealth Basic or Plus for remaining family members, with grantee ineligible.

Determine CommonHealth eligibility

- Complete PACES TD.
 - Enter appropriate action reasons in Blocks 33 and 89 based on client's coverage type
 - Date of eligibility:
 - If Medicaid is closed = date CommonHealth enrollment form is received.
 - If Medicaid is not closed = day after Medicaid ends.
- Complete PACES Worksheet entering:
 - gross income based on earnings, child support, and other income;
 - family size if different from number of persons listed on PACES TD; and
 - amount paid for employer-offered health insurance, if applicable.
- If eligible, PACES sends appropriate CommonHealth approval letter.
 - If insurance is available through the employer, PACES will determine the amount of the Department's contribution toward employer-offered health insurance.
 - Client will receive first payment effective the first month of eligibility.

- Notify Third Party Liability (TPL) Unit when CommonHealth Basic or Plus is approved.
 - Send copies of both sides of the enrollment form to TPL.
- Issue temporary CommonHealth card if requested for medical needs during period before client receives MassHealth card for CommonHealth Basic.
- Client receives MassHealth card.
- If ineligible because of income, PACES sends CommonHealth denial letter.
 - If ineligible individual is disabled, determine eligibility for CommonHealth as a disabled adult (see Employed Disabled Adult section).
- Complete SMARTS Transmittal sheet for key entry.

Policy
Reference

CommonHealth Policy
Manual

Citation

Welfare to Work

513.000 - 513.600

Case
Maintenance
Activities

- Issue temporary CommonHealth Basic card when necessary for clients who are not currently enrolled in HMO's.
- Review family income, availability of employer or other third-party insurance.
 - One year after enrollment;
 - When changes are reported; or
 - When waiting period ends for employer health insurance.
- Review availability of and participation in employer's health insurance plan every six months for CommonHealth Assist cases.

- Complete PACES Worksheet to:
 - adjust Department's contribution toward employer-offered premium (if appropriate); and
 - send notice advising client of new amount.
- If employer-offered health insurance becomes available to a CommonHealth Basic or Plus enrollee:
 - Complete PACES Worksheet and TD. PACES will:
 - determine eligibility for CommonHealth Assist;
 - determine amount of Department's contribution; and
 - send approval letter informing client of amount of Department's contribution.
- If client wishes to disenroll from HMO and chooses CommonHealth Basic, notify HMO representative to complete disenrollment paperwork.
- Complete PACES TD and/or Worksheet to close case.
- PACES sends closing letter giving either advance notice or adequate notice depending upon the closing reason (see PACES User's Guide).
- If client reports a change in income:
 - Verify income of all family members.
 - Complete PACES Worksheet. PACES will:
 - determine if income is below 185% of federal poverty level; and
 - adjust Department's contribution to employer-offered health insurance.
- If client reports a change in household composition:
 - Add or remove family member on PACES TD.
 - PACES sends appropriate notification letter.
- If client moves:
 - Complete PACES TD to change address and, if necessary, transfer case.
 - Review HMO's accessibility to client.
 - PACES sends notice to client when case transfers.
 - Tell client to contact worker in new office.

**Replacing a
Check**

- Send referral to HMO marketing representative when:
 - Client moves;
 - Case closes; or
 - Household composition changes.

If client reports CommonHealth Assist check is lost, stolen, or not received:

- Confirm that the check was issued and mailed to correct address.
- See if the check has been returned to office and remail.
- Complete FCB-1 with your client.
- Give the FCB-1 to Data Entry Operator:
 - immediately - when your client received the check and then it was lost or stolen; or
 - after waiting 2 days beyond check date - when the check was delayed in the mail and your client confirms nonreceipt.
- Meet with your client if FCB-2 is received from Finance to review signature on cashed check.
- Help your client complete FCB-3 when requested by Finance because the original check was cashed and signature on check is not your client's signature:
 - contact Finance (617-348-5030) when FCB-3 is signed;
 - send NFL-9 to deny replacement if your client refuses to sign FCB-3.
- Check the Local Office Recipient Replacement Check Register and send NFL-9 to your client when replacement check has been issued.

**Policy
Reference**

AFDC Policy Manual

Citation

Lost and Stolen Checks

306.500 - 306.520

Reminders

- CommonHealth Basic clients will receive a MassHealth card.
 - TPL closes case on CommonHealth Basic and opens on CommonHealth Plus when client is enrolled in HMO.
 - Client receives HMO card (MassHealth card will no longer be valid).
- CommonHealth Assist clients will not receive a card. They will receive a monthly check as a contribution toward the cost of their employer-offered health insurance.
 - When taking any action on CommonHealth Assist cases, always enter worker number 840 in block 7 of the PACES TD so these cases are not added to the MMIS recipient file.

Overview



People with disabilities often have difficulty obtaining health insurance through their employers. Many health insurance plans won't cover people with "pre-existing conditions" or, when they do, they often don't offer coverage for the disability-related service.

This problem can be alleviated for many disabled adults who are working and cannot get adequate health insurance. **CommonHealth** offers primary or supplemental health insurance for a premium that is based on the disabled adult's income and coverage needs.

CommonHealth:

- Provides full medical coverage when they are unable to obtain health insurance;
- Helps to ensure that there are no gaps in medical coverage while disabled adults wait for their employers' health insurance plan to cover them;
- Provides coverage that will help them pay for services related to their disability that are not covered by their employer's plan;
- Allows them greater dignity to return to or remain working; and
- Provides a sense of security with the knowledge that they will have adequate health insurance.

Worker
Responsibilities

Assess potential eligibility for Medicaid

- Review CommonHealth enrollment form.
 - Ensure that client provides complete information, particularly about availability of health insurance, program preference, and who in the family is to be covered.
 - If a quick assessment of the family income and asset situation suggests Medicaid eligibility - or even a small spenddown - the family should be encouraged to complete a Medicaid application.
 - Obtain the information or verifications necessary to process for Medicaid.
 - Send CommonHealth denial letter.
- If client is legally blind, refer to Mass. Commission for the Blind.

Determine CommonHealth eligibility

- Determine if client is employed.
 - A client who receives any earned income is considered employed regardless of the number of hours he or she works.
- Explain that the client, as a condition of CommonHealth eligibility, must maintain any existing health insurance and must obtain health insurance available through his or her place of employment, unless the employer-offered health insurance does not cover the client's pre-existing condition.
- Determine if client is eligible for a federal work incentive program.

- If client is receiving RSDI or SSI, he or she may be eligible for a Medicaid extension under a special federal work incentive program, such as 1619(B).
 - * The 1619(B) Work Incentive program offered by SSA allows certain recipients to continue receiving SSI and Medicaid. A person working, despite a disability impairment, may still be eligible for Medicaid even if his or her earnings exceed the established substantial gainful activity limits of \$300 gross per month. A disabled person who would normally lose SSI because of earnings may be eligible for an extension of Medicaid under this program.
- If client who is currently receiving RSDI or SSI has not explored eligibility for a federal work incentive program, refer him or her to the Social Security District office.
 - * Advise client to inform you of SSA's determination;
 - * Continue eligibility process for **CommonHealth** if client is not eligible for a federal work incentive program.
- Determine the status of the client's disability determination.
 - If client is receiving SSI or RSDI:
 - * Call the Massachusetts Rehabilitation Commission (MRC) Inquiry line (617-654-7729) for verification of disability determination.
 - * Provide client's name and SSN and ask for the case status.
 - * If MRC has a disability determination on file, ask for the medical diary date (the date, if any, that the disability must be reviewed).
 - If client is a current or former MA/DA recipient:
 - * Check the case record for a disability determination from MRC's disability determination unit (or the State Medical Review Team) and the diary date, if any.

- If MRC has verified disability and indicates a future disability determination is "waived," the disability is permanently verified and does not need to be re-viewed again.
- If MRC has verified disability but requires a review at a future date, annotate this date in the case record.
- If no verification of disability is available from MRC, have client submit other evidence of disability such as a copy of the client's Medicare card, RSDI check, or a statement from SSA verifying disability.
 - For these cases, redetermine disability in three years by having client complete Disability Supplement at that time.
 - Annotate case record to show review date.
- If there is no disability determination:
 - Have client complete the Disability Supplement.
 - Complete Part VII of the Disability Supplement with client, if a face-to-face interview is requested.
 - Complete the top half of the tracking form and forward it and the completed Disability Supplement to MRC.
- If MRC determines client does not meet disability criteria:
 - Determine whether client is eligible for **CommonHealth** under the Welfare to Work program; and
 - If not eligible, send CommonHealth denial letter.
- If disability is established by MRC:
 - Record review date, if any, in the case record.
 - Complete PACES TD.
 - * Enter code F in block 16 to ensure PACES sends TPL a copy of the notification letter with the premium amount.

- Complete PACES Worksheet.
 - Enter client's gross income and family size.
 - Enter the following information in the FTW4 section to ensure PACES sends TPL a copy of the notification letter with the premium amount.
 - Name: CH Premiums
 - Dept/Title: TPL Unit
 - Street: PO Box 68, Essex Sta.
 - State: MA
 - Zip: 02112
 - Add Type: E1
- PACES determines the CommonHealth premium amount based on whether client has existing health insurance.
- PACES sends CommonHealth approval letter to client and to TPL indicating the premium amount.

Establishing CommonHealth Case

- Complete a separate PACES TD for each disabled family member.
- Eligibility date = the date the signed enrollment form is received in the local office. The first premium payment is due for the calendar month following the CommonHealth approval month.
- Send copies of both sides of the enrollment form to TPL if client has health insurance.
- Issue client a temporary CommonHealth card if necessary.
- The system sends the recipient:
 - a MassHealth card; and
 - TPL billing approval notice indicating premium amount.
- TPL billing sends monthly premium notice to recipient.

**Policy
Reference**

CommonHealth Policy Manual
Employed Disabled Adults

Citation
514.000 - 514.600

**Case
Maintenance
Activities**

- Review family income and availability of employer or other third-party insurance:
 - Annually;
 - When changes are reported;
 - When waiting period ends for employer health insurance; or
 - When client whose case was closed because of failure to pay premium requests reinstatement more than 90 days after date of termination.
- Complete PACES TD and/or Worksheet:
 - when family income changes; and/or
 - when client who had no insurance obtains third-party insurance.
- Code PACES TD to indicate the availability of other insurance, if appropriate.
- PACES determines if reported changes result in new premium payment.
 - PACES sends notice of new premium amount to client and TPL.
 - New premium amount is effective the first calendar month following the month the change is reported.
- Review client's disability at scheduled review date.
- Complete PACES TD to close case.
- PACES sends closing letter giving either advance notice or adequate notice depending upon the closing reason (see PACES User's Guide).

- Complete PACES Worksheet and TD to reopen case if requested by client who was terminated because of failure to pay premium.
 - Call TPL to determine if account is paid in full.
 - If payment was sent but has not yet been posted, check again with TPL within two days to see if payment is posted.
 - Reopen case if account balance = \$0, and issue a temporary CommonHealth card.
 - Inform client of balance if account > \$0.
- Issue temporary CommonHealth card, when necessary.
- If client is admitted to a long-term-care facility:
 - Determine MA eligibility before establishing a long-term-care segment under CommonHealth.
 - If client is not MA eligible, be sure level of care has been certified in accordance with MA leveling requirements.
 - Code PACES TD for long-term care and complete an LTCTD to authorize payment to facility.
 - Complete PACES TD to close CommonHealth case at the end of the third calendar month after employment ends; review potential eligibility for MA at that time.
- If client moves:
 - Complete PACES TD to change address and, if necessary, transfer case.
 - PACES sends notice to client when case transfers.
 - Tell client to contact worker in new office.

Overview



The road to quality health care for children with disabilities has many obstacles.

- Many private insurers:
 - Are reluctant to provide coverage because of the high cost of care for these children; and
 - Provide only limited coverage.
- Medicaid:
 - Provides comprehensive medical coverage; but
 - Has very low income and asset limits, which forces families either to institutionalize their child or incur large spenddown expenses before being able to access care; and
 - Discourages many parents from taking higher paying jobs that would cause them to lose the medical coverage their children need.

Some of these barriers have been removed with the establishment of the Kaileigh Mulligan Home Care for Disabled Children Program which:

- Provides Medicaid eligibility for certain severely disabled children without regard to the financial situation of the parents; but
- Benefits those children who are at risk of institutionalization in a hospital or pediatric nursing home and require extensive support services in order to remain at home.

CommonHealth helps even more children by making health insurance available for a premium to a much larger group of disabled children regardless of their family's financial status and whether or not they are at risk of institutionalization.

Worker
Responsibilities

Explore coverage possibilities

- Families of disabled children who come to you seeking assistance may be confused by their options, and while you are not medically qualified to determine the severity of their child's disability, you can provide the family some much needed guidance.
 - Assess potential financial eligibility for Medicaid.
 - Apply the more liberal SSI-related disregards to the family's gross income.
 - If a quick assessment of the family income and asset situation suggests Medicaid eligibility - or even a small spenddown - the family should be encouraged to complete a Medicaid application.
 - Obtain the information or verifications necessary to process for Medicaid.
 - Send CommonHealth denial letter.
 - If, however, the family income is significantly in excess of Medicaid standards, you should help the family decide if their child might meet the disability criteria of the Kaileigh Mulligan program or if they should pursue eligibility under CommonHealth.

Help Family Make Choice between Kaileigh Mulligan Program or CommonHealth

- Provide both informational brochures to family.
- Have them compare the eligibility requirements and the benefit packages.
- Explain that the family, as a condition of CommonHealth eligibility, must maintain any existing health insurance for the child, including benefits available under Chapter 766, and must obtain health insurance available through the parent's employer, unless the employer-offered health insurance does not cover the child's pre-existing condition.
- Explain that the Kaileigh Mulligan Program charges no premiums and that the benefit package is more extensive.

- Stress that the Kaileigh Mulligan Program requires that the child be at risk of institutionalization.
- Ask if the child is dependent upon services such as tracheostomy, ventilator, intravenous therapy, etc.
 - If the answer is yes, there is a greater chance of eligibility for the Kaileigh Mulligan Program.
 - If the answer is no, they should pursue **CommonHealth**, but tell the family they have the option of pursuing eligibility for the Kaileigh Mulligan Program after the child becomes CommonHealth-eligible.
- Most families will most appropriately be referred to **CommonHealth**.
 - Explain that the CommonHealth process will result in a quicker eligibility determination and more immediate health care access for their child.
 - Call the Kaileigh Mulligan Program staff at Central Office if, in your judgment, you have a borderline case or if you would like more direction about whether Kaileigh Mulligan would be appropriate.
- The option of both programs are open to the family.
 - It's their choice - but do your best to help them make the one that is best suited to their child's needs.

Process CommonHealth Enrollment Form

- If the child is legally blind, refer to the Mass. Commission for the Blind.
- Determine the status of the child's disability determination.
 - If child is receiving SSI or RSDI:
 - Call MRC Inquiry line (617-654-7729) for verification of disability determination.
 - Provide child's name and SSN and ask for the case status.

- If MRC has a disability determination on file, ask for the medical diary date (the date, if any, that the disability must be reviewed).
- If child is a current or former MA/DA recipient:
 - Check the case record for a disability determination from MRC's disability determination unit (or the State Medical Review Team) and the diary date, if any.
- If MRC has verified disability and indicates a future disability determination is "waived," the disability is permanently verified and does not need to be reviewed again.
- If MRC has verified disability but requires a review at a future date, annotate this date in the case record.
- If no verification of disability is available from MRC, have family submit other evidence of child's disability such as a copy of the child's RSDI check or a statement from SSA verifying disability.
 - For these cases, redetermine disability in three years by having family complete Disability Supplement at that time.
 - Annotate case record to show review date.
- If there is no disability determination:
 - Have family complete the Disability Supplement.
 - Complete the top half of the tracking form and forward it and the completed Disability Supplement to MRC.
- If disability is not approved by MRC, send CommonHealth denial letter.
- If disability is approved:
 - Record review date, if any, in case record.

Establishing CommonHealth Case

- Complete PACES TD in child's name and use child's SSN.
 - Complete a separate PACES TD for each disabled child in family.

- Eligibility date = the date the signed enrollment form is received in the local office. The first premium payment is due for the calendar month following the CommonHealth approval month.
 - Complete PACES TD.
 - Enter code F in block 16 to ensure PACES sends TPL a copy of the notification letter with the premium amount.
 - Complete PACES Worksheet.
 - Enter family's gross income and family size.
 - Enter the following information in the FTW4 section to ensure PACES sends TPL a copy of the notification letter with the premium amount.

Name: CH Premiums
Dept/Title: TPL Unit
Street: PO Box 68, Essex Sta.
State: MA
Zip: 02112
Add Type: E1
 - PACES determines the CommonHealth premium payment based on whether the child has existing health insurance.
 - PACES sends approval letter to client and to TPL indicating the premium amount.
 - Send Kaileigh Mulligan brochure to family.
 - Send copy of enrollment form to Kaileigh Mulligan Unit if enrollment form indicates child is technology-dependent (Section IV, question #5 of enrollment form) and if the family expresses interest in the program.
- Send copies of both sides of the enrollment form to TPL.
- Issue family a temporary CommonHealth card for the child, if necessary.
- The system sends the recipient:
 - a MassHealth card; and
 - TPL billing approval notice indicating premium amount.
- TPL billing sends monthly premium notice to recipient.

Opting for Kaileigh Mulligan Program

- A family may still opt to apply for the Kaileigh Mulligan Program after receiving their CommonHealth approval letter.
 - If family opts for Kaileigh Mulligan, program staff may request information, such as the disability supplement or enrollment form, from you to determine eligibility.
- If Kaileigh Mulligan application is approved:
 - Send family Medicaid application pages requesting asset information and related materials.
 - Request required verifications (e.g., child's assets, residence, citizenship).
 - Complete PACES TD to close CommonHealth case in child's name and SSN.
 - Complete PACES TD in child's name and use child's SSN to establish Medicaid case on category 7.
 - Medical start date = date of receipt of CommonHealth enrollment form.
 - PACES sends approval letter to client.
- If Kaileigh Mulligan application is denied, no further action is necessary.

**Policy
Reference**

*CommonHealth Policy
Manual*

Citation

Disabled Children

515.000-515.500

Medicaid Policy Manual

Citation

Home Care for Disabled
Children

507.200

**Procedure
Reference**

*Medicaid Procedures
Handbook*

Citation

Kaileigh Mulligan Home
Care for Disabled Children
Program

7600

**Case
Maintenance
Activities**

- Review family income and availability of employer or other third-party insurance.
 - Annually;
 - When changes are reported;
 - When waiting period ends for employer health insurance; or
 - When client whose case was closed because of failure to pay premium requests reinstatement more than 90 days after date of termination.
- Complete PACES TD and/or Worksheet:
 - when family income changes; and/or
 - when the family obtains third-party insurance for the child who was previously uninsured.
- Code PACES TD to indicate the availability of other insurance, if appropriate.
- PACES determines if reported changes result in new premium payment.
 - PACES sends notice of new premium amount to family and TPL (if code F has been entered on TD and TPL information has been entered on Worksheet).
 - New premium amount is effective the first calendar month following the month the change is reported.
- Review child's disability at scheduled review date.
- Complete PACES TD to close case.
- PACES sends closing letter giving either advance notice or adequate notice depending upon the closing reason (see PACES User's Guide).
- Complete PACES Worksheet and TD to reopen case if requested by enrollee who was terminated because of failure to pay premium. (Access screens to check information on file.)
 - Call TPL to determine if account is paid in full.
 - If payment was sent but has not yet been posted, check again with TPL within two days to see if payment is posted.

- Reopen case if account balance = \$0, and issue a temporary CommonHealth card.
- Inform enrollee of balance if account > \$0.
- Issue temporary CommonHealth card, when necessary.
- If client is admitted to a long-term-care facility:
 - Determine MA eligibility before establishing a long-term-care segment under **CommonHealth**. (Most children will be eligible after the first calendar month of separation from their parents).
 - If client is not MA eligible, be sure medical care has been certified in accordance with MA requirements.
 - Complete an LTCTD to authorize payment to facility and code PACES TD for long-term care.
- If client moves:
 - Complete PACES TD to change address and, if necessary, transfer case.
 - PACES sends notice to family when case transfers.
 - Tell family to contact worker in new office.

Temporary or Replacement CommonHealth ID Cards

CommonHealth

5- 1

Worker Responsibilities



Eligible CommonHealth Enrollee requests Temporary or Replacement CommonHealth ID Card (ID-2)

When to issue card:

- Prior to issuance of computer-generated card at client's request; or
- When original ID card is lost, stolen, or not issued timely.
 - Access Mass REVS screens to verify recipient eligibility.
 - Complete MassHealth Card Update Request to issue a replacement card.

The CommonHealth ID-2 Card:

- is a gray card with red ink; and
- must contain in the message area:
 - any medical service restriction messages (such as other health insurance available, if any);
 - the Carrier Code;
 - Policy Number = Recipient's SSN; and
 - Coverage Type.

New and Reopened Cases (Temporary Cards)

- Complete and submit a PACES TD making all entries necessary for establishing the case on the Recipient Masterfile.
 - Give copy of PACES TD to ID Control Clerk.
 - Indicate in "Remarks" section on PACES TD:
 - any medical service restriction messages;
 - Carrier Code;
 - Recipient SSN;
 - Coverage Type; and
 - type of CommonHealth coverage (e.g., Basic, Extra Adults, Extra Children).

CommonHealth

- Instruct ID Control Clerk to type the following information (as indicated in the "Remarks" section on PACES TD) on the card:

In the "message" section of the card:

- restriction messages, if any; and
 - indicate insurance company's name and policy number; and
 - if this information is not available, type the message, "Recipient has Third-Party Insurance".
- Carrier Code, Recipient SSN, and Coverage Type.

On the left front side of card under title, "CommonHealth Card":

- indicate which coverage applies (e.g., Basic, Extra Adults, Extra Children).
 - do not type REG., LWO, CAT., and LWO phone number.
 - The phone numbers for Client Services and CommonHealth Provider Services Unit will be printed on the reverse of card.
 - enter the "Eligible From" date (i.e., the date of issuance of the temporary card) on the card.
 - enter the "Thru" date (i.e., 10 days from the date of issuance of the temporary card) on the card.
- Send or give original ID-2 to applicant.
 - Tell applicant to sign it immediately.
 - File copy in case record.

Ongoing Cases (Replacement Cards)

- Check return mail control log to determine if regular card has been returned.
- Refer to the MMIS MID screen for the information needed to complete the ID-2. (Bottom left of screen will indicate gray card = CommonHealth.)

Temporary or Replacement CommonHealth ID Cards

CommonHealth

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- Print copy of screen and give to ID Control Clerk (screen will include all restriction messages, codes, eligible dates, etc. to be typed on gray card).
 - Type this information on card as it appears on screen.
- Send or give original ID-2 to recipient.
 - Tell recipient to sign it immediately.
 - File copy in case record.
- Complete MassHealth Card Update Request to issue a replacement MassHealth card.

Temporary CommonHealth Card Codes

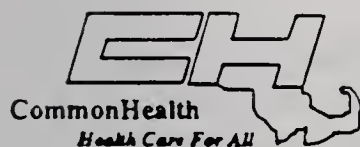
Program	Carrier Code	Coverage Type
Welfare to Work - Basic	907	41
Disabled Adults	911	45
Disabled Children	912	46

Appendix

Covered Services

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CommonHealth



The following medical services are available under the **CommonHealth** program to Welfare to Work enrollees. Restrictions may apply to certain services.

CommonHealth Basic

Inpatient Hospital Care
Physician Services
X-Ray and Laboratory Services
Mental Health Services (Limited)
Outpatient Hospital Care
Physical-Speech-Occupational
Therapy
Durable Medical Equipment
(Limited)
Home Health Care
Family Planning
Nurse Midwife Services
Drug Treatment Services
Private Duty Nursing

CommonHealth Plus

Inpatient Hospital Care
Physician Services
X-Ray and Laboratory Services
Pharmacy*
Mental Health Services
Outpatient Hospital Care
Physical-Speech-Occupational
Therapy
Durable Medical Equipment
Home Health Care
Family Planning
Skilled Nursing Care
Nurse Midwife Services*

*Plan benefits may vary depending upon the HMO or health center chosen by the enrollee.

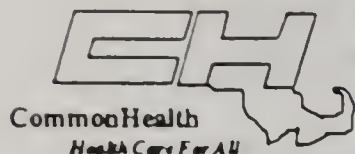
The following medical services are available under **CommonHealth** to Disabled Adults/Children enrollees. Restrictions may apply to certain services.

CommonHealth Extra

Inpatient Acute Hospital
Services
X-Ray and Laboratory Services
Physician Services
Home Health Services
Preventive Services
Family Planning Services
Skilled Nursing Facility Services
Intermediate Care Facility
Services
Nurse Midwife Services
Outpatient Hospital Services
Drug Treatment Services

Dental Services
Prescription Drugs
Ambulance Services
Private Duty Nursing Services
Mental Health Clinic Services
Durable Medical Equipment
Physical-Speech-Occupational
Therapy
Personal Care
Eyeglasses
Chiropractic Services
Podiatry
Transportation

CommonHealth



This listing provides acceptable forms of verifications that are required to determine eligibility for Welfare to Work, Disabled Adults, and Disabled Children. Any other documentation presented that reasonably verifies the requirement should be accepted. Inform enrollees that if any difficulty is encountered in obtaining a necessary verification, you are available to assist them.

Residence

Verification is required *only* if questionable. Possible sources could include a deed, lease, rental receipt, utility bill, mortgage payment, collateral statement, etc.

Disability

Possible sources of verification of disability include evidence of receipt of either SSI disability or Social Security disability payments or a disability determination confirmed by MRC. Instructions on methods to confirm disability are contained in the procedural guidelines for either Employed Disabled Adults or Disabled Children.

Medical Insurance

A written statement from an employer attesting to the lack of availability of health insurance is acceptable. If insurance is available, a recent pay stub indicating the employee's deduction for the premium or a written statement from the employer attesting to either the amount of the employee's contribution or the fact that the health insurance does not cover the employee's pre-existing disabling condition is acceptable.

Earned Income

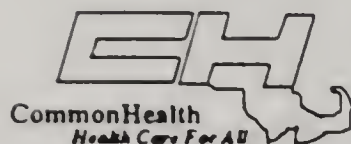
Possible sources for verifying earnings include: pay stubs or a signed statement from employer; tax returns; accounting records; appropriate documents indicating gross proceeds/expenses from self-employed enterprises; signed statements or written agreements which confirm information provided by enrollee if other traditional verification documents are not available.

Verification Guidelines
CommonHealth

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**Unearned
Income**

Verifications can include: a copy of the benefit check or award letter; a written statement from the agency or organization making the payment; tax records; interest; dividend or royalty checks or statements; signed statements by an appropriate source confirming the information provided if traditional documents are unavailable.



The following forms are used in the administration of **CommonHealth**. This chart describes their purpose and the program for which they are used, if appropriate.

Form	Welfare to Work	Disabled Children	Disabled Adults	Description
Enrollment Form	x	x	x	Application and annual review
Program-specific Cover Letter and Tips CH-2 & 6	x	x	x	Introduces program and provides instructions for completing Enrollment Form and requests verification
Disability Supplements and Tracking Form MADS-A & MADS-C		x	x	Used by Mass. Rehab. to make a disability determination
Request for More Information CH-15	x	x	x	Requests verifications needed to establish and review eligibility
Denial Letter CH-17	x	x	x	Provides reason for CommonHealth ineligibility
FCB-1.2.3 NFL-9	x			Notifies CommonHealth Assist client of check replacement process

TD Tips



- Always submit a TD to close one CommonHealth program before opening another CommonHealth program.
- If two category 6 cases exist (on **CommonHealth** or Medicaid) with the same grantee, you must use a dummy social security number for one of the cases. For example, if only the grantee is being approved for CommonHealth Assist (Individual), but the dependent(s) remain on Basic, use a dummy number for the Assist case.
- CommonHealth Assist cases receive checks only. They do not receive MassHealth cards. You must always enter worker number 840 in block 7 to make sure they do not receive cards.

